

**PROVIDER AGENCY SELF-CERTIFICATION FORM
BEHAVIORAL HEALTH OVERLAY SERVICES –
CHILD WELFARE**

Provider Agency Name: _____ Medicaid No. _____

Provider Agency Address: _____

City: _____ Zip Code _____ Phone No.: () _____

County: _____ District: _____ Area: _____

Name and Address of Site: _____

_____ Zip Code _____

This is to certify that the above named provider agency has conducted a self-survey of the above named site and determined that the provider and site are in compliance with the certification criteria, presented in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, including the following:

1. Is an enrolled Medicaid Community Behavioral Health Services provider;
2. Is licensed by the Department of Children and Families under Chapter 64C-14, F.A.C. as a child caring agency and is under contract with Child Welfare and Community Based Care office or provider to provide group shelter or residential group care.
3. Has as the primary mission in this program to provide an alternative living situation to children who have been removed from the home due to abuse or neglect or adjudicated dependent;
4. Is designated by the Department Children and Families as an essential behavioral health care provider; and
5. Will cooperate with an on-site survey by the district SAMH and Child Welfare offices for the purpose of provider agency certification within six months of this self-certification and agrees to adhere to the provisions for provider qualifications and certification criteria. These certification criteria include:

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| • Services to be provided | • Staffing ratios |
| • Provider capacity | • Qualifications and responsibilities |
| • Intensity of services | • Clinical supervision |
| • Quality assurance program | • Behavioral health overlay services design |
| • Required policies and procedures | • Recipient eligibility |
| • Organizational chart and staff credentials | • Recipient certification and re-certification |
| • Clinical staffing requirements | • Medical record and documentation requirements |

I certify that the above named site is in compliance with Medicaid policies and procedures as put forth in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook and with the specific standards for Behavioral Health Overlay Services – Child Welfare as included in the Behavioral Health Overlay Services – Child Welfare On-Site Certification Survey Form dated 10/1/04. I further certify that statements made in this document are accurate and correct to the best of my knowledge.

Executive Director's Signature _____ Date _____

Executive Director's Name (please print) _____

Send original form to AHCA, Medicaid Services, Long Term and Behavioral Health Unit, 2727 Mahan Drive, Mail Stop #20, Tallahassee FL 32308. Provider should maintain a copy.